

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-020715

FILED VS. MAY 18 1960

318

1003

4920

STATE FILE NUMBER

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|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <u>Missouri</u> COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Saint Louis</u> | | Length of stay in 1b <u>45 yrs.</u> | c. CITY OR TOWN <u>Saint Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Infirmary</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>4424 West Belle</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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|---|----------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES E. BRANCH</u> | | | 4. DATE OF DEATH Month Day Year <u>May 8, 1960</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/4/83</u> | 9. AGE (last birthday) <u>76</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>--</u> | 11. BIRTHPLACE (City and state or country) <u>Farmville, Va.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Lewis R. Bolling</u> | | 13b. MOTHER'S MAIDEN NAME <u>Betty Dean</u> | | 14. NAME OF HUSBAND OR WIFE <u>Samuel Branch</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT Address <u>Martha Burghardt 4424 W. Belle</u> | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Colon</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <u>153.8</u> | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |

21. I attended the deceased from March 23, 1960 to May 8, 1960 and last saw her alive on May 7, 1960
Death occurred at May 8, 1960 5:35 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>James M. Whittier, M.D.</u> | | 22b. ADDRESS <u>916 A. No. Taylor St. St. Louis, Mo.</u> | | 22c. DATE SIGNED <u>5-9-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>5/11/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery St. Louis, Missouri</u> | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR <u>Charles J. Gates 4107 Finney</u> | | 25. DATE RECD. BY LOCAL REG. <u>MAY 10 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> |

DOCUMENT

MEDICAL CERTIFICATION

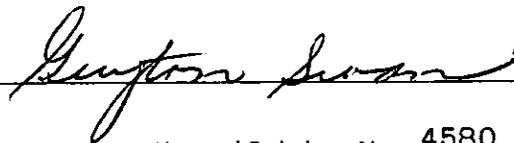
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4580

P. O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.